

Composite of

TITLE XVIII

of the

SOCIAL SECURITY ACT

And

H. R. 5710

INTRODUCED
IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 20, 1967



DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
Bureau of Health Insurance

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INTRODUCTION

This composite act device has been prepared to reflect the changes which will be made in title XVIII of the Social Security Act if H.R. 5710, as introduced by Mr. Mills on February 20, 1967, is enacted into law.

The materials used to prepare this composite act device consists of the Administration issued loose-leaf edition of the Social Security Act and H.R. 5710 as introduced.

In this composite act, provisions which will be deleted are stricken through. Provisions which are to be added are identifiable by the fact that the material is in larger sized type and is double spaced, or appears in the margins as inserts to the present text of the law. In addition, each addition or deletion is accompanied by an appropriate marginal reference to the amending bill. For effective dates, see the listing at the end of the composite

Basic Policy Branch
Division of Policy & Standards
Bureau of Health Insurance

Entitlement to Hospital Insurance Benefits

Sec. 226. (a) Every individual who—

(1)

(A)

Sec. 125(a)(1)

~~(1)~~ has attained the age of 65, and

~~(2)~~ is entitled to monthly insurance benefits under section 202 or is a qualified railroad retirement beneficiary,

(B)

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in ~~paragraph (2)~~, beginning with the first month after June 1966 for which he meets the conditions specified in ~~paragraphs (1) and (2)~~.

subparagraph (B)

subparagraph (A
and (B)

[An individual will be deemed to have attained age 65

Sec. 165(a)

if he is alive on the first day of the month he attains age 65 even though he dies prior to attaining such age.

(2) Every individual who—

Sec. 125(a)(1)

(A) has not attained age 65, but

(B) (i) is entitled to disability insurance benefits under section 223, or (ii) has attained the age of 18 and is entitled to child's insurance benefits under section 202 (d) and is under a disability (as defined in section 223 (c)) which began before he attained age 18, or (iii) has not attained age 62 and is entitled to widow's insurance benefits on the basis of being under

a disability (as so defined), or (iv) is a qualified railroad retirement beneficiary,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month beginning with the later of (a) January 1968 or (b) the first month for which he satisfies the applicable conditions of subparagraph (B), and

ending with the eleventh month after the first month in which he ceases to meet the applicable conditions of subparagraph (B) or, if earlier, with the month before the month in which he attains age 65. Notwithstanding clause (iii) of subparagraph (B), a widow or surviving divorced wife who has attained age 62 shall be deemed to have satisfied the applicable conditions of such subparagraph (B) in any month in which (i) she is entitled to benefits under section 202 (e) (or would be but for paragraph (i) (E) of such section 202 (e)) and (ii) she would be entitled to such benefits (but without regard to such paragraph (1) (E)) on the basis of being under a disability (as defined in section 223 (c)) had the period, specified in section 202 (e) (5), ended in the month she attains 65, instead of the month she attains 62; and the first month in which she shall be deemed not to have satisfied such applicable conditions shall be the eleventh month following the first month in which such benefits would have been terminated on the basis of the concurrence of an event specified in section 202 (e) (1) .

Sec. 125(a)(1)

(b) For purposes of subsection (a) —

Sec. 130(c)(13)

Sec. 126(a)

Sec. 125(d)(2)

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, ~~post-hospital home health services, and outpatient hospital diagnostic services~~ ^{and} (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814~~(17)~~) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services or post-hospital home health services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII ^(e) qualify such services for payment under part A of title XVIII occurred ⁽ⁱ⁾ after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, ←

or (ii) if he was entitled to hospital insurance benefits pursuant to paragraph (2) of subsection (a), at a time when he was so entitled (but only if there has been no intervening termination of such entitlement) ; and

(2) an individual shall be deemed entitled to monthly insurance beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

(c) For purposes of this section, the term "qualified railroad retirement beneficiary" means an individual whose name has been certified to the Secretary by the Railroad Retirement Board under section 21 of the Railroad Retirement Act of 1937. An individual shall cease to be a qualified railroad retirement beneficiary at the close of the month preceding the month which is certified by the Railroad Retirement Board as the month in which he ceased to meet the requirements of section 21 of the Railroad Retirement Act of 1937.

(d) For entitlement to hospital insurance benefits in the case of certain uninsured individuals, see section 103 of the Social Security Amendments of 1965.

TITLE XVIII—HEALTH INSURANCE FOR THE AGED**Prohibition Against Any Federal Interference**

Sec. 1801. Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.

Free Choice by Patient Guaranteed

Sec. 1802. Any individual entitled to insurance benefits under this title may obtain health services from any institution, agency, or person qualified to participate under this title if such institution, agency, or person undertakes to provide him such services.

Option to Individuals To Obtain Other Health Insurance Protection

Sec. 1803. Nothing contained in this title shall be construed to preclude any State from providing, or any individual from purchasing or otherwise securing, protection against the cost of any health services.

Part A—Hospital Insurance Benefits for the Aged**Description of Program**

Sec. 1811. The insurance program for which entitlement is established by section 226 provides basic protection against the costs of hospital and related post-hospital services in accordance with this part for individuals who are age 65 or over and are entitled to retirement benefits under title II of this Act or under the railroad retirement system.

Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf (subject to the provisions of this part) for—

- (1) inpatient hospital services for up to 90 days during any spell of illness;

(2) post-hospital extended care services for up to 100 days during any spell of illness. ~~and~~ and

(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next ~~and~~ and

~~(4) outpatient hospital diagnostic services.~~

(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 90 days during such spell;

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

(c) If an individual is an inpatient of a psychiatric hospital or a tuberculosis hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 90-day period immediately before such first day shall be included in determining the 90-day limit under subsection (b) (1) ~~(but not in determining the 190-day limit under subsection (b) (3)).~~

insofar as such limitation applies to inpatient psychiatric hospital services or to inpatient tuberculosis hospital services, as the case may be

(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.

(e) For purposes of subsections (b), (c), and (d), inpatient hospital services, inpatient psychiatric hospital services, post-hospital extended care services, and post-hospital home health services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

Deductibles and Coinsurance

Sec. 1813. (a) (1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the

customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell.

Sec. 130(c)(4)

~~(2) The amount payable for outpatient hospital diagnostic services furnished an individual during a diagnostic study shall be reduced by a deduction equal to the sum of (A) one-half of the inpatient hospital deductible which is applicable to spells of illness beginning in the same calendar year as such diagnostic study and (B) 20 per centum of the remainder of such amount. For purposes of the preceding sentence, a diagnostic study for any individual consists of the outpatient hospital diagnostic services provided by (or under arrangements made by) the same hospital during the 20-day period beginning on the first day (not included in a previous diagnostic study) on which he is entitled to hospital insurance benefits under section 226 and on which outpatient hospital diagnostic services are furnished him.~~

~~(3) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by an amount equal to the cost of the first three pints of whole blood furnished to him as part of such services during such spell of illness.~~

~~(4) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.~~

(b)(1) The inpatient hospital deductible which shall be applicable for the purposes of subsection (a) shall be \$40 in the case of any spell of illness or diagnostic study beginning before 1969.

Sec. 130(c)(5)

(2) The Secretary shall, between July 1 and October 1 of 1968, and of each year thereafter, determine and promulgate the inpatient hospital deductible which shall be applicable for the purposes of subsection (a) in the case of any spell of illness ~~or diagnostic study~~ beginning during the succeeding calendar year. Such inpatient hospital deductible shall be equal to \$40 multiplied by the ratio of (A) the current average per diem rate for inpatient hospital services for the calendar year preceding the promulgation, to (B) the current average per diem rate for such services for 1966. Any amount determined under the preceding sentence which is not a multiple of \$4 shall be rounded to the nearest multiple of \$4 (or, if it is midway between two multiples of \$4, to the next higher multiple of \$4). The current average per diem rate for any year shall be determined by the Secretary on the basis of the best information available to him (at the time the determination is made) as to the amounts paid under this part on account of inpatient hospital services furnished during such year, by hospitals which have agreements in effect under section 1866, to individuals who are entitled to hospital insurance benefits under section 226, plus the amount which would have been so paid but for subsection (a) (1) of this section.

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

Sec. 126(a)

Sec. 1814. (a) Except as provided in subsection ~~(A)~~, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(c)

(1) written request, signed by such individual except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulation prescribe;

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

Sec. 131(a)(1)

~~(A) in the case of inpatient hospital services (other than inpatient psychiatric hospital services and inpatient tuberculosis hospital services), such services are or were required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is or was medically required and such services are or were necessary for such purpose;~~

Sec. 131(a)(2)

~~(B)~~ in the case of inpatient psychiatric hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the psychiatric treatment of an individual; and (i) such treatment can or could reasonably be expected to improve the condition for which such treatment is or was necessary or (ii) inpatient diagnostic study is or was medically required and such services are or were necessary for such purposes;

(A)

Sec. 131(a)(2)

~~(C)~~ in the case of inpatient tuberculosis hospital services, such services are or were required to be given on an inpatient basis, by or under the supervision of a physician, for the treatment of an individual for tuberculosis; and such treatment can or could reasonably be expected to (i) improve the condition for which such treatment is or was necessary or (ii) render the condition non-communicable;

(B)

Sec. 131(a)(2)

~~(D)~~ in the case of post-hospital extended care services, such services are or were required to be given on an inpatient basis because the individual needs or needed skilled nursing care on a continuing basis for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (8) of section 1861(e)) prior to transfer to the extended care facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the

(C)

Sec. 130(c)(6)(A)	condition or conditions for which he was receiving such inpatient hospital services; ~~Λ~~ <u>or</u> (D)
Sec. 131(a)(2)	~~Λ(E)~~ in the case of post-hospital home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (8) of section 1861(e)) or post-hospital extended care services; a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; ~~or~~
Sec. 130(c)(6)(B)	~~(F) in the case of outpatient hospital diagnostic services, such~~
Sec. 130(c)(6)(C)	~~services are or were required for diagnostic study;~~

(3) with respect to inpatient hospital services.

Sec. 131(a)(4) (other than inpatient psychiatric hospital services and inpatient tuberculosis services) a physician certifies, in those cases where such services are furnished over a period of time, that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose, except that (A) such certification shall be furnished only in such cases, with such frequency, and accompanied by such supporting material, appropriate to the cases involved, as may be provided by regulation, and (B) the first such certification required under clause (A) shall be furnished no later than the 20th day of such period;

- Sec. 131(a)(3) ~~^(3)~~ in the case of inpatient psychiatric hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving (A) intensive treatment services, (B) admission and related services necessary for a diagnostic study, or (C) equivalent services; (4)
- Sec. 131(a)(3) ~~^(4)~~ in the case of inpatient tuberculosis hospital services, the services are those which the records of the hospital indicate were furnished to the individual during periods when he was receiving treatment which could reasonably be expected to (A) improve his condition or (B) render it noncommunicable; (5)
- Sec. 131(a)(3) ~~^(5)~~ with respect to inpatient hospital services furnished such individual after the 20th day of a continuous period of such services and with respect to post-hospital extended care services furnished after such day of a continuous period of such services as may be prescribed in or pursuant to regulations, there was not in effect, at the time of admission of such individual to the hospital or extended care facility, as the case may be, a decision under section 1866(d) (based on a finding that utilization review of long-stay cases is not being made in such hospital or facility); and (6)
- Sec. 131(a)(3) ~~^(6)~~ with respect to inpatient hospital services or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4)) pursuant to the system of utilization review that further inpatient hospital services or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or extended care facility, as the case may be, received notice of such finding. (7)
- Sec. 130(a)(7) To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), ~~^(D), (E), or (F)~~ of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. or (D)
- Sec. 131(a)(5)

Reasonable Cost of Services

(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1813, be the reasonable cost of such services, as determined under section 1861(v).

~~No Payments to Federal Providers of Services~~

- Sec. 126(a) ~~(c) No payment may be made under this part (except under subsection (d)) to any Federal provider of services, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services for any item or service which such provider is obligated by a law of, or a contract with, the United States to render at public expense.~~

Payments for Emergency Hospital Services

Sec. 126(a)

Sec. 130(c)(8)

~~(d)~~ Payments shall also be made to any hospital for inpatient hospital services or outpatient hospital diagnostic services furnished, by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services and (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(c)

Sec. 126(a)

Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

~~(c)~~ Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for the services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or legal holiday) after the day on which such admission occurred.

(d)

Payment for Certain Emergency Hospital Services Furnished Outside the United States

Sec. 126(a)

~~(4)~~ The authority contained in subsection ~~(d)~~ shall be applicable to emergency inpatient hospital services furnished an individual by a hospital located outside the United States if—

(e)

(c)

(1) such individual was physically present in a place within the United States at the time the emergency which necessitated such inpatient hospital services occurred; and

(2) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

Payment to Providers of Services

Sec. 1815. The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting

Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

**Use of Public Agencies or Private Organizations to
Facilitate Payment to Providers of Services**

Sec. 1816. (a) If any group or association of providers of services wishes to have payments under this part to such providers made through a national, State, or other public or private agency or organization and nominates such agency or organization for this purpose, the Secretary is authorized to enter into an agreement with such agency or organization providing for the determination by such agency or organization (subject to such review by the Secretary as may be provided for by the agreement) of the amount of the payments required pursuant to this part to be made to such providers, and for the making of such payments by such agency or organization to such providers. Such agreement may also include provision for the agency or organization to do all or any part of the following: (1) to provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as hospitals, extended care facilities, or home health agencies, and (2) with respect to the providers of services which are to receive payments through it (A) to serve as a center for, and communicate to providers, any information or instructions furnished to it by the Secretary, and serve as a channel of communication from providers to the Secretary; (B) to make such audits of the records of providers as may be necessary to insure that proper payments are made under this part; and (C) to perform such other functions as are necessary to carry out this subsection.

(b) The Secretary shall not enter into an agreement with any agency or organization under this section unless (1) he finds (A) that to do so is consistent with the effective and efficient administration of this part, and (B) that such agency or organization is willing and able to assist the providers to which payments are made through it under this part in the application of safeguards against unnecessary utilization of services furnished by them to individuals entitled to hospital insurance benefits under section 226, and the agreement provides for such assistance, and (2) such agency or organization agrees to furnish to the Secretary such of the information acquired by it in carrying out its agreement under this section as the Secretary may find necessary in performing his functions under this part.

(c) An agreement with any agency or organization under this section may contain such terms and conditions as the Secretary finds necessary or appropriate, may provide for advances of funds to the agency or organization for the making of payments by it under subsection (a), and shall provide for payment of so much of the cost of administration of the agency or organization as is determined by the Secretary to be necessary and proper for carrying out the functions covered by the agreement.

(d) If the nomination of an agency or organization as provided in this section is made by a group or association of providers of services, it shall not be binding on members of the group or association which notify the Secretary of their election to that effect. Any provider may, upon such notice as may be specified in the agreement under this section with an agency or organization, withdraw its nomination to receive payments through such agency or organization. Any provider which has withdrawn its nomination, and any provider which has not made a nomination, may elect to receive payments from any agency or organization which has entered into an agreement with the Secretary under this section if the Secretary and such agency or organization agree to it.

(e) An agreement with the Secretary under this section may be terminated—

(1) by the agency or organization which entered into such agreement at such time and upon such notice to the Secretary, to the public, and to the providers as may be provided in regulations, or

(2) by the Secretary at such time and upon such notice to the agency or organization, to the providers which have nominated it for purposes of this section, and to the public, as may be provided in regulations, but only if he finds, after reasonable notice and opportunity for hearing to the agency or organization, that (A) the agency or organization has failed substantially to carry out the agreement, or (B) the continuation of some or all of the functions provided for in the agreement with the agency or organization is disadvantageous or is inconsistent with the efficient administration of this part.

(f) An agreement with an agency or organization under this section may require any of its officers or employees certifying payments or disbursing funds pursuant to the agreement, or otherwise participating in carrying out the agreement, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(g) (1) No individual designated pursuant to an agreement under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such agency or organization shall be liable to the United States for any payments referred to in paragraph (1) and (2).

Federal Hospital Insurance Trust Fund

Sec. 1817. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Hospital Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part. There are hereby appropriated to the Trust Fund for the fiscal year ending June 30, 1966, and for each fiscal year thereafter, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to 100 per centum of—

(1) the taxes imposed by section 3101(b) and 3111(b) of the Internal Revenue Code of 1954 with respect to wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of such

Code after December 31, 1965, as determined by the Secretary of the Treasury by applying the applicable rates of tax under such sections to such wages, which wages shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with such reports; and

(2) the taxes imposed by section 1401(b) of the Internal Revenue Code of 1954 with respect to self-employment income reported to the Secretary of the Treasury or his delegate on tax returns under subtitle F of such Code, as determined by the Secretary of the Treasury by applying the applicable rate of tax under such section to such self-employment income, which self-employment income shall be certified by the Secretary of Health, Education, and Welfare on the basis of records of self-employment established and maintained by the Secretary of Health, Education, and Welfare in accordance with such returns.

The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in such sentence.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of ~~March~~ April of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgement, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond

Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Any obligations acquired by the Trust Fund (except public-debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) (1) The Managing Trustee is directed to pay from time to time from the Trust Fund into the Treasury the amount estimated by him as taxes imposed under section 3101(b) which are subject to refund under section 6413(c) of the Internal Revenue Code of 1954 with respect to wages paid after December 31, 1965. Such taxes shall be determined on the basis of the records of wages established and maintained by the Secretary of Health, Education, and Welfare in accordance with the wages reported to the Secretary of the Treasury or his delegate pursuant to subtitle F of the Internal Revenue Code of 1954, and the Secretary of Health, Education, and Welfare shall furnish the Managing Trustee such information as may be required by the Managing Trustee for such purpose. The payments by the Managing Trustee shall be covered into the Treasury as repayments to the account for refunding internal revenue collections.

(2) Repayments made under paragraph (1) shall not be available for expenditures but shall be carried to the surplus fund of the Treasury. If it subsequently appears that the estimates under such paragraph in any particular period were too high or too low, appropriate adjustments shall be made by the Managing Trustee in future payments.

(g) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retirement Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(h) The Managing Trustee shall also pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g)(1).

Part B—Supplementary Medical Insurance Benefits for the Aged

Establishment of Supplementary Medical Insurance Program for the Aged

Sec. 1831. There is hereby established a voluntary insurance program to provide medical insurance benefits in accordance with the provisions of this part for individuals 65 years of age or over who elect to enroll under such program, to be financed from premium payments by enrollees together with contributions from funds appropriated by the Federal Government.

Scope of Benefits

Sec. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consists of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in paragraph (2)(B); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services for up to 100 visits during a calendar year; and

(B) medical and other health services (other than physicians' services ~~unless furnished by a resident or intern of a hospital~~) furnished by a provider of services or by others under arrangements with them made by a provider of services.

(b) For definitions of "spell of illness", "medical and other health services", and other terms used in this part, see section 1861.

Payment of Benefits

Sec. 1833. (a) Subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be

Sec. 161(a)

paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b); and

(2) in the case of services described in section 1832(a)(2)—80 percent of the reasonable cost of the services (as determined under section 1861(v)).

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of \$50; except that (1) of the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year (or regarded under clause (2) as incurred in such preceding year with respect to services furnished in such last three months) and applied toward such individual's deductible under this section for such preceding year, and (2) the amount of any deduction imposed under section ~~1813(a)(2)(A)~~ with respect to ~~outpatient hospital diagnostic services~~ furnished in any calendar year shall be regarded as an incurred expense under this part for such year.

1852(b)

services to hospital
outpatients

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only whichever of the following amounts is the smaller:

- (1) \$312.50, or
- (2) 62½ percent of such expenses.

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813 ~~other than subsection (a)(2)(A) thereof~~) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

Limitation on Home Health Services

Sec. 1834. (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100

visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.

Sec. 126(b)

Procedure for Payment of Claims of Providers of Services

Sec. 1835. (a) Payment for services described in section 1832(a) (2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

Sec. 126(b)

(1) written request, signed by such individual except in cases in which the Secretary finds it impracticable for the individual to do so, is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulations prescribe; and

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) in the case of home health services (i) such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(m) (7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, (ii) a plan for furnishing such services to such individual has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; and

(B) in the case of medical and other health services, such services are or were medically required.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations.

~~(b) No payment may be made under this part to any Federal provider of services or other Federal agency, except a provider of services which the Secretary determines is providing services to the public generally as a community institution or agency; and no such payment may be made to any provider of services or other person for any item or service which such provider or person is obligated by a law of, or a contract with, the United States to render at public expense.~~

Sec. 126(b)

Eligible Individuals

Sec. 1836. Every individual who—

(1) is entitled to hospital insurance benefits under part A, or

Sec. 125(a)(3)

~~(1) has attained the age of 65, and~~ (2)
~~(2) (A) is a resident of the United States, and is either (i) a citizen or (ii) an alien lawfully admitted for permanent residence who has resided in the United States continuously during the 5 years immediately preceding the month in which he applies for enrollment under this part, or (B) is entitled to hospital insurance benefits under part A,~~ (A) (B)
 is eligible to enroll in the insurance program established by this part.

Sec. 165(b)

An individual will be deemed to have attained age 65 if he is alive on the first day of the month he attains age 65 even though he dies prior to attaining such age.

Enrollment Periods

Sec. 1837. (a) An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section.

~~(b) (1) No individual may enroll for the first time under this part more than 3 years after the close of the first enrollment period during which he could have enrolled under this part.~~

(1) No individual may enroll for the first time (in ec. 125(a)(4)(A) any continuous period of eligibility) under this part more than 3 years after the close of the first enrollment period (in such continuous period of eligibility) during which he could have enrolled under this part.

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ec. 125(a)(4)(B)	(2) An individual whose enrollment under this part has terminated may not enroll for the second time under this part unless he does so in a general enrollment period (as provided in subsection (e)) which begins within 3 years after the effective date of such termination. No individual may enroll under this part more than twice	(during any continuous period of eligibility)
ec. 125(a)(4)(C)		

(3) For purposes of paragraphs (1) and (2) (and section 1839 (c)), individual's "continuous period of eligibility" is the period beginning with the first day on which he is eligible to enroll under section 1836 and ending with his death; except that any period during all of which an individual satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which he attained age 65 shall be a separate "continuous period of eligibility" with respect to such individual (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this section or section 1839 (c)).

Sec. 125(a)(4)(E)

(c) In the case of individuals who first satisfy ~~paragraphs (1) and (2)~~ of section 1836 before March 1, 1966, the initial general enrollment period shall begin on the first day of the second month which begins after the date of enactment of this title and shall end on May 31, 1966. ~~For purposes of this subsection and subsection (d), an individual who satisfies paragraph (2) of section 1836 solely by reason of subparagraph (B) thereof shall be treated as satisfying such paragraph (2) on the first day on which he is (or on filing application would be) entitled to hospital insurance benefits under part A.~~

paragraph
(1) or (2)

For purposes of this

Sec. 125(a)(4)(F)

subsection and subsection (d), an individual who has attained age 65 and who satisfies paragraph (1) of section 1836 but not paragraph (2) of such section shall be treated as satisfying such paragraph (1) on the first day on which he is (or on filing application would have been) entitled to hospital insurance benefits under part A. ↗

Sec. 125(a)(4)(G)

(In the case of an individual who has not attained age 65 and who first satisfies paragraph (1) of section 1836 before August 1967, the initial enrollment period shall begin on June 1, 1967, and shall end on October 31, 1967.

~~(d) In the case of an individual who first satisfies paragraphs (1) and (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month in which he first satisfies such paragraphs and shall end seven months later.~~

Sec. 125(a)(4)(H)

(d) In the case of an individual who, with respect to the period beginning with the month in which he attains age 65, first satisfies paragraph (1) or (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall begin on the first day of the third month before the month

in which he first satisfies such paragraph and shall end seven months later. In the case of an individual who has not attained age 65 and who first satisfies paragraph (1) of section 1836 after July 1967, his initial enrollment period shall begin on the day—

(1) he files his application for disability insurance benefits under section 223, or

(2) the widow or surviving divorced wife files her application for widow's insurance benefits under section 202 (e) , or

(3) he files his application for child's insurance benefits under section 202 (d) after attaining age 18 on the basis of being under a disability (as defined in section 223 (c))

and shall end at the close of the fourth month following the month in which he is mailed notice of a final disability determination. In the case of a child entitled to child's insurance benefits before attaining age 18, such initial enrollment period shall begin on the first day of the sixth month preceding the month he attains such age but only if a determination is made that such child is under a disability (as so defined) which began before he attained age 18.

Where the Secretary finds that an individual failed to enroll under this part during his initial enrollment period (based on a determination by the Secretary of the

month in which such individual attained age 65), because such individual was mistaken as to his correct date of birth, the Secretary shall establish for such individual an initial enrollment period based on the documentary evidence of attainment of age 65 on the basis of which he initially sought to enroll.

(e) There shall be a general enrollment period, after the period described in subsection (c), during the period beginning on October 1 and ending on December 31 of each odd-numbered year beginning with 1967.

(f) For purposes of subsections (b), (c), and (d) of this section (and for purposes of sections 1838 (a) and 1839 (c)), any enrollment under this part which terminates in the manner described in section 1838 (c) shall thereafter be deemed not to have existed.

Coverage Period

Sec. 1838. (a) The period during which an individual is entitled to benefits under the insurance program established by this part (hereinafter referred to as his "coverage period") shall begin on whichever of the following is the latest:

(1) ~~July 1, 1966, or~~

~~July 1, 1966, or~~ July 1, 1966, or (in the case of an individual who has not attained age 65) January 1, 1968 ; or

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.125(a)(5)(A)(ii)	(2) (A) in the case of an individual who enrolls pursuant to subsection (d) of section 1837 before the month in which he first satisfies ~~paragraphs (1) and (2)~~ of section 1836, the first day of such month, or	(who has attained age 65) paragraph (1) or (2)
paragraph	(B) in the case of an individual who enrolls pursuant to such subsection (d) in the month in which he first satisfies such ~~paragraph~~ , the first day of the month following the month in which he so enrolls, or.	(who has attained age 65)
.125(a)(5)(A)(iii)	(C) in the case of an individual who enrolls pursuant to such subsection (d) in the month following the month in which he first satisfies such ~~paragraphs~~ , the first day of the second month following the month in which he so enrolls, or	(who has attained age 65) paragraph
	(D) in the case of an individual who enrolls pursuant to such subsection (d) more than one month following the month in which he satisfies such ~~paragraphs~~ , the first day of the third month following the month in which he so enrolls, or	(who has attained age 65) paragraph
	(E) in the case of an individual who enrolls pursuant to subsection (e) of section 1837, the July 1 following the month in which he so enrolls	, or

(3) (A) in the case of an individual who has not attained age 65 and who enrolls pursuant to subsection (d) of 1837 in a month prior to the month in which he is mailed notice of a final determination of disability, the first day of the month in which he is mailed such notice, or

.125(a)(5)(A)(iv)

(B) in the case of an individual who has not attained age 65 and who enrolls pursuant to subsection (d) of 1837 in the month in which he is mailed such notice, or the first month thereafter, the first day of the month following the month in which he so enrolls, or

(C) in the case of an individual who has not attained age 65 and who enrolls pursuant to subsection (d) of 1837 in the second month following the month in which he is mailed such notice, the first day of the second month following the month in which he so enrolls, or

Sec.125(a)(5)(A)(iv) (D) in the case of an individual who has not attained age 65 and who enrolls pursuant to subsection (d) of 1837 more than two months following the month in which he is mailed such notice, the first day of the third month following the month in which he so enrolls.

(b) An individual's coverage period shall continue until his enrollment has been terminated—

(1) by the filing of notice, during a general enrollment period described in section 1837(e), that the individual no longer wishes to participate in the insurance program established by this part, or

(2) for nonpayment of premiums.

The termination of a coverage period under paragraph (1) shall take effect at the close of December 31 of the year in which the notice is filed. The termination of a coverage period under paragraph (2) shall take effect on a date determined under regulations, which may be determined so as to provide a grace period (not in excess of 90 days) in which overdue premiums may be paid and coverage continued.

Sec.125(a)(5)(B) (c) In the case of an individual satisfying paragraph (1) of section 1836 whose entitlement to hospital insurance benefits under part A is based on a disability rather than on his having attained the age of 65, his coverage period (and his enrollment under this part) shall be terminated as of the close of the last month for which he is entitled to hospital insurance benefits.

~~(e)~~ No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to him, is a coverage period. (d)

Amounts of Premiums

Sec. 1839. (a) The monthly premium of each individual enrolled under this part for each month before 1968 shall be \$3.

(b) (1) The monthly premium of each individual enrolled under this part for each month after 1967 shall be the amount determined under paragraph (2).

(2) The Secretary shall, between July 1 and October 1 of 1967 and of each odd-numbered year thereafter, determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in either of the two succeeding calendar years. Such dollar amount shall be such amount as the Secretary estimates to be necessary so that the aggregate premiums for such two succeeding calendar years will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for such two succeeding calendar years. In estimating aggregate benefits payable for any period, the Secretary shall include an appropriate amount for a contingency margin.

(c) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (b) shall be increased by 10 percent of the monthly premium so determined for each full 12 months ~~in which he could have been~~ but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who enrolls for a second time) (2) the months which elapsed between the date of the termination of his first coverage period and the close of the enrollment period in which he enrolled for the second time. ↗

(in the same continuous period of eligibility)

Sec. 125(a)(6)(A)

↖ Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

Sec. 125(a)(6)(B)

(d) If any monthly premium determined under the foregoing provisions of this section is not a multiple of 10 cents, such premium shall be rounded to the nearest multiple of 10 cents.

Payment of Premiums

Sec. 1840. (a) (1) In the case of an individual who is entitled to monthly benefits under section 202, ~~his monthly premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.~~

or 223

Sec. 125(a)(7)(A)

c.125(a)(7)(B)

(2) The Secretary of the Treasury shall, from time to time, transfer from the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates from benefits under section 202 which are payable from such Trust Fund. Such transfer shall be made on the basis of a certification by the Secretary of Health, Education, and Welfare and shall be appropriately adjusted to the extent that prior transfers were too great or too small. or 223

(b)(1) In the case of an individual who is entitled to receive for a month an annuity or pension under the Railroad Retirement Act of 1937, his monthly premiums under this part shall (except as provided in subsection (d)) be collected by deducting the amount thereof from such annuity or pension. Such deduction shall be made in such manner and at such times as the Secretary shall by regulations prescribe. Such regulations shall be prescribed only after consultation with the Railroad Retirement Board.

(2) The Secretary of the Treasury shall, from time to time, transfer from the Railroad Retirement Account to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfers shall be made on the basis of a certification by the Railroad Retirement Board and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

ec.125(a)(7)(C)

(c) In the case of an individual who is entitled both to monthly benefits under section 202 and to an annuity or pension under the Railroad Retirement Act of 1937 at the time he enrolls under this part, subsection (a) shall apply so long as he continues to be entitled both to such benefits and such annuity or pension. In the case of an individual who becomes entitled both to such benefits and such an annuity or pension after he enrolls under this part, subsection (a) shall apply if the first month for which he was entitled to such benefits was the same as or earlier than the first month for which he was entitled to such annuity or pension, and otherwise subsection (b) shall apply. or 223

(d) If an individual to whom subsection (a) or (b) applies estimates that the amount which will be available for deduction under such subsection for any premium payment period will be less than the amount of the monthly premiums for such period, he may (under regulations) pay to the Secretary such portion of the monthly premiums for such period as he desires.

(e)(1) In the case of an individual receiving an annuity under the Civil Service Retirement Act, or other Act administered by the Civil Service Commission providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health, Education, and Welfare to the Civil Service Commission, be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Civil Service Commission may determine. The Civil Service Commission

shall furnish such information as the Secretary of Health, Education, and Welfare may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies.

(2) The Secretary of the Treasury shall, from time to time, but not less often than quarterly, transfer from the Civil Service Retirement and Disability Fund, or the account (if any) applicable in the case of such other Act administered by the Civil Service Commission, to the Federal Supplementary Medical Insurance Trust Fund the aggregate amount deducted under paragraph (1) for the period to which such transfer relates. Such transfer shall be made on the basis of a certification by the Civil Service Commission and shall be appropriately adjusted to the extent that prior transfers were too great or too small.

(f) In the case of an individual who participates in the insurance program established by this part but with respect to whom none of the preceding provisions of this section applies, or with respect to whom subsection (d) applies, the premiums shall be paid to the Secretary at such times, and in such manner, as the Secretary shall by regulations prescribe.

(g) Amounts paid to the Secretary under subsection (d) or (f) shall be deposited in the Treasury to the credit of the Federal Supplementary Medical Insurance Trust Fund.

(h) In the case of an individual who participates in the insurance program established by this part, premiums shall be payable for the period commencing with the first month of his coverage period and ending with the month in which he dies or, if earlier, in which his coverage under such program terminates.

(i) In the case of an individual who is enrolled under the program established by this part as a member of a coverage group to which an agreement with a State entered into pursuant to section 1843 is applicable, subsections (a), (b), (c), (d), and (e) of this section shall not apply to his monthly premium for any month in his coverage period which is determined under section 1843(d).

Federal Supplementary Medical Insurance Trust Fund

Sec. 1841. (a) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Supplementary Medical Insurance Trust Fund" (hereinafter in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, all ex officio. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Commissioner of Social Security shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

(1) Hold the Trust Fund;

(2) Report to the Congress not later than the first day of ~~March~~ of each year on the operation and status of the Trust Fund during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next 2 fiscal years;

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(3) Report immediately to the Congress whenever the Board is of the opinion that the amount of the Trust Fund is unduly small; and

(4) Review the general policies followed in managing the Trust Fund, and recommend changes in such policies, including necessary changes in the provisions of law which govern the way in which the Trust Fund is to be managed.

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall be printed as a House document of the session of the Congress to which the report is made.

(c) It shall be the duty of the Managing Trustee to invest such portion of the Trust Fund as is not, in his judgment, required to meet current withdrawals. Such investments may be made only in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. For such purpose such obligations may be acquired (1) on original issue at the issue price, or (2) by purchase of outstanding obligations at the market price. The purposes for which obligations of the United States may be issued under the Second Liberty Bond Act, as amended, are hereby extended to authorize the issuance at par of public-debt obligations for purchase by the Trust Fund. Such obligations issued for purchase by the Trust Fund shall have maturities fixed with due regard for the needs of the Trust Fund and shall bear interest at a rate equal to the average market yield (computed by the Managing Trustee on the basis of market quotations as of the end of the calendar month next preceding the date of such issue) on all marketable interest-bearing obligations of the United States then forming a part of the public debt which are not due or callable until after the expiration of 4 years from the end of such calendar month; except that where such average market yield is not a multiple of one-eighth of 1 per centum, the rate of interest on such obligations shall be the multiple of one-eighth of 1 per centum nearest such market yield. The Managing Trustee may purchase other interest-bearing obligations of the United States or obligations guaranteed as to both principal and interest by the United States, on original issue or at the market price, only where he determines that the purchase of such other obligations is in the public interest.

(d) Any obligations acquired by the Trust Fund (except public debt obligations issued exclusively to the Trust Fund) may be sold by the Managing Trustee at the market price, and such public-debt obligations may be redeemed at par plus accrued interest.

(e) The interest on, and the proceeds from the sale or redemption of, any obligations held in the Trust Fund shall be credited to and form a part of the Trust Fund.

(f) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Federal Old-Age and Survivors Insurance Trust Fund and from the Federal Disability Insurance Trust Fund amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments (other than amounts so certified to the Railroad Retire-

ment Board) pursuant to section 1870(b) of this Act. There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Railroad Retirement Account amounts equivalent to the amounts not previously so transferred which the Secretary of Health, Education, and Welfare shall have certified as overpayments to the Railroad Retirement Board pursuant to section 1870(b) of this Act.

(g) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to make the payments provided for by this part, and the payments with respect to administrative expenses in accordance with section 201(g) (1).

(h) The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Secretary of Health, Education, and Welfare certifies are necessary to pay the costs incurred by the Civil Service Commission in making deductions pursuant to section 1840(e). During each fiscal year, or after the close of such fiscal year, the Civil Service Commission shall certify to the Secretary the amount of the costs it incurred in making such deductions, and such certified amount shall be the basis for the amount of such costs certified by the Secretary to the Managing Trustee.

Use of Carriers for Administration of Benefits

Sec. 1842. (a) In order to provide for the administration of the benefits under this part with maximum efficiency and convenience for individuals entitled to benefits under this part and for providers of services and other persons furnishing services to such individuals, and with a view to furthering coordination of the administration of the benefits under part A and under this part, the Secretary is authorized to enter into contracts with carriers, including carriers with which agreements under section 1816 are in effect, which will perform some or all of the following functions (or, to the extent provided in such contracts, will secure performance thereof by other organizations); and, with respect to any of the following functions which involve payments for physicians' services, the Secretary shall to the extent possible enter into such contracts:

(1)(A) make determinations of the rates and amounts of payments required pursuant to this part to be made to providers of services and other persons on a reasonable cost or reasonable charge basis (as may be applicable);

(B) receive, disburse, and account for funds in making such payments; and

(C) make such audits of the records of providers of services as may be necessary to assure that proper payments are made under this part;

(2)(A) determine compliance with the requirements of section 1861(k) as to utilization review; and

(B) assist providers of services and other persons who furnish services for which payment may be made under this part in the development of procedures relating to utilization practices, make studies of the effectiveness of such procedures and methods for their improvement, assist in the application of safeguards against unnecessary utilization of services furnished by providers of services and other persons to individuals entitled to benefits under this part, and provide procedures for and assist in arranging, where necessary, the establishment of groups outside hospitals (meeting the requirements of section 1861(k) (2)) to make reviews of utilization;

(3) serve as a channel of communication of information relating to the administration of this part; and

(4) otherwise assist, in such manner as the contract may provide, in discharging administrative duties necessary to carry out the purposes of this part.

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, (i) such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and (ii) such payment will be made on the basis of a receipted bill, or on the basis of an assignment under the terms of which the reasonable charge is the full charge for the service;

(except as otherwise provided in section 1870(f))

services

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness of when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

(4) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out

Sec. 153(d)

the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

(c) Any contract entered into with a carrier under this section shall provide for advances of funds to the carrier for the making of payments by it under this part, and shall provide for payment of the cost of administration of the carrier, as determined by the Secretary to be necessary and proper for carrying out the functions covered by the contract.

(d) Any contract with a carrier under this section may require such carrier or any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(e) (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.

(2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.

(3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

(f) For purposes of this part, the term "carrier" means—

(1) with respect to providers of services and other persons, a voluntary association, corporation, partnership, or other nongovernmental organization which is lawfully engaged in providing, paying for, or reimbursing the cost of, health services under group insurance policies or contracts, medical or hospital service agreements, membership or subscription contracts, or similar group arrangements, in consideration of premiums or other periodic charges payable to the carrier, including a health benefits plan duly sponsored or underwritten by an employee organization; and

(2) with respect to providers of services only, any agency or organization (not described in paragraph (1)) with which an agreement is in effect under section 1816.

**State Agreements for Coverage of Eligible Individuals
Who Are Receiving Money Payments Under
Public Assistance Programs**

(OR ARE ELIGIBLE
FOR MEDICAL ASSISTANCE)

Sec. 1843. (a) The Secretary shall, at the request of a State made before January 1, ~~1968~~, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

1970

c. 222(b)(3)

c.222(e)(1)

(b) An agreement entered into with any State pursuant to subsection (a) may be applicable to either of the following coverage groups:

(1) individuals receiving money payments under the plan of such State approved under title I or title XVI; or

(2) individuals receiving money payments under all of the plans of such State approved under titles, I, IV, X, XIV, and XVI.

Except as provided in subsection (g), there shall be excluded from any coverage group any individual who is entitled to monthly insurance benefits under title II or who is entitled to receive an annuity or pension under the Railroad Retirement Act of 1937.

(c) For purposes of this section, an individual shall be treated as an eligible individual only if he is an eligible individual (within the meaning of section 1836) on the date an agreement covering him is entered into under subsection (a) or he becomes an eligible individual (within the meaning of such section) at any time after such date ~~and before January 1, 1968~~; and he shall be treated as receiving money payments described in subsection (b) if he receives such payments for the month in which the agreement is entered into or any month thereafter ~~before January 1, 1968~~.

(d) In the case of any individual enrolled pursuant to this section—

(1) the monthly premium to be paid by the State shall be determined under section 1839 (without any increase under subsection (c) thereof);

(2) his coverage period shall begin on whichever of the following is the latest:

(A) July 1, 1966;

(B) the first day of the third month following the month in which the State agreement is entered into;

(C) the first day of the first month in which he is both an eligible individual and a member of a coverage group specified in the agreement under this section; or

(D) such date ~~(not later than January 1, 1968)~~ as may be specified in the agreement; and

(3) his coverage period attributable to the agreement with the State under this section shall end on the last day of whichever of the following first occurs:

(A) the month in which he is determined by the State agency to have become ~~ineligible for money payments of a kind specified in the agreement, or~~

ineligible both for money payments

of a kind specified in the agreement and (if there is in effect

a modification entered into under subsection (h)) for medi-

cal assistance, ~~or~~

(B) the month preceding the first month for which he becomes entitled to monthly benefits under title II or to an annuity or pension under the Railroad Retirement Act of 1937.

(e) Any individual whose coverage period attributable to the State agreement is terminated pursuant to subsection (d) (3) shall be deemed for purposes of this part (including the continuation of his coverage period under this part) to have enrolled under section 1837 in the initial general enrollment period provided by section 1837(c).

Sec.222(e)(2)(A)

Sec.222(e)(2)(B)

Sec.222(e)(3)

Sec.222(b)(1)

TITLE XVIII OF THE ACT

(f) With respect to eligible individuals receiving money payments under the plan of a State approved under title I, IV, X, XIV, or XVI ↗

Sec. 222(b)(2)(A)

or eligible to receive medical assistance under the plan of such State approved under title XIX, ↗

if the agreement entered into under this section so provides, the term "carrier" as defined in section 1842(f) also includes the State agency, specified in such agreement, which administers or supervises the administration of the plan of such State approved under title I, XVI, or XIX. The agreement shall also contain such provisions as will facilitate the financial transactions of the State and the carrier with respect to deductions, coinsurance, and otherwise, and as will lead to economy and efficiency of operation, with respect to individuals receiving money payments under plans of the State approved under titles I, IV, X, XIV, and XVI ↗

and individuals eligible to receive medical assistance

Sec. 222(b)(2)(B)

under the plan of the State approved under title XIX.

(g)(1) The Secretary shall, at the request of a State made before January 1, 1968, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

(2) In the case of any individual who would (but for this subsection) be excluded from the applicable coverage group described in subsection (b) by the second sentence of such subsection—

(A) subsections (c) and (d)(2) shall be applied as if such subsections referred to the modification under this subsection (in lieu of the agreement under subsection (a)),

(B) subsection (d)(3)(B) shall not apply so long as there is in effect a modification entered into by the State under this subsection, and

(C) notwithstanding subsection (e), in the case of any termination described in such subsection, such individual may terminate his enrollment under this part by the filing of a notice, before the close of the third month which begins after the date of such termination, that he no longer wishes to participate in the insurance program established by this part (and in such a case, the termination of his coverage period under this part shall take effect as of the close of such third month).

(h) (1) The Secretary shall, at the request of a State made before January 1, 1970, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

(2) For purposes of this section, an individual shall be treated as eligible to receive medical assistance under the plan of the State approved under title XIX if, for the month in which the modification is entered into under this subsection or for any month thereafter, he has been determined to be eligible to receive medical assistance under such plan. In the case of any individual who would (but for this subsection) be included from the agreement, subsections (c) and (d) (2) shall be applied as if they referred to the modification under this subsection (in lieu of the agreement under subsection (a)), and subsection (d) (2) (C) shall be applied by substituting "second month following the first month" for "first month".

**Appropriations to Cover Government Contributions and
Contingency Reserve**

Sec. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund, a Government contribution equal to the aggregate premiums payable under this part.

(b) In order to assure prompt payment of benefits provided under this part and the administrative expenses thereunder during the early months of the program established by this part, and to provide a contingency reserve, there is also authorized to be appropriated, out of any moneys in the Treasury not otherwise appropriated, to remain available through the calendar year 1967 for repayable advances (without interest) to the Trust Fund, an amount equal to \$18 multiplied by the number of individuals (as estimated by the Secretary) who could be covered in July 1966 by the insurance program established by this part if they had theretofore enrolled under this part.

**PART C—OUTPATIENT HOSPITAL AND DIAGNOSTIC
SPECIALTY BENEFITS FOR THE AGED AND DISABLED**

“DESCRIPTION OF PROGRAM

Sec. 130(a)

SEC. 1850. There is hereby established as a complement to the programs under part A and part B a special program related to the services furnished to individuals under such part A and part B programs providing for the payment for hospital services rendered to hospital outpatients and for the payment for diagnostic specialty services to hospital inpatients and outpatients.

SCOPE OF BENEFITS

SEC. 1851. The benefits provided to an individual by the insurance program established by this part shall consist of entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for—

(a) services to hospital outpatients; and

(b) diagnostic specialty services to hospital inpatients.

For definitions of "services to hospital outpatients" and "diagnostic specialty services" see section 1861 (p) and (z), respectively.

AMOUNT OF BENEFITS

Sec.130(a) SEC. 1852. (a) Subject to the succeeding provisions of this section, there shall be paid, in the case of each individual who is covered under the program established under this part and who incurs expenses for services with respect to which benefits are payable under this part, an amount equal to—

(1) in the case of hospital services included in section 1851 (a), 80 per cent of the reasonable cost of the services;

(2) in the case of diagnostic specialty services to hospital outpatients included in section 1851 (a), 80 per cent of the reasonable charges for the services; and

(3) in the case of services described in section 1851 (b), the reasonable charges for the services.

(b) Before applying subsections (a) (1) and (a) (2) with respect to expenses incurred for services described in section 1851 (a) by an individual during any calendar year,

the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of \$50; except that the amount of the deductible for such calendar year shall be reduced by the amount of any deductible imposed under section 1833 (b) .

“ELIGIBLE INDIVIDUALS

SEC. 1853. (a) Every individual who is eligible to enroll and has enrolled in the insurance program established by part B shall be entitled to have payment made for services, described in section 1851 (a) (subject to the provisions of section 1852), which are furnished him in the periods during which he is entitled to have payment made under such part for services described in section 1832 (a) .

Sec.130(a)

(b) Every individual who is entitled (under section 226 and section 103 of the Social Security Amendments of 1965) to have payment made on his behalf under part A for inpatient hospital services furnished during any month shall be entitled to have payment made under this part for services described in section 1851 (b) furnished him in such month as an inpatient in a hospital which is eligible for payment under section 1866 (a) .

PAYMENT OF CLAIMS OF HOSPITALS

Sec.130(a) SEC. 1854. (a) Payment for services described in section 1851 (a) (except to the extent that such services are included under diagnostic specialty services) furnished an individual may be made only to hospitals which are eligible therefor under section 1866 (a) , and only if a written request is filed for such payment in such form, in such manner, within such time, and by such person or persons as the Secretary may by regulation prescribe.

(b) Payments shall also be made to any hospital for services to hospital outpatients (except to the extent that services are included under diagnostic specialty services) furnished, by the hospital or under arrangements (as defined in section 1861 (w)) with it, to an individual entitled under this part even though such hospital does not have an agreement in effect under this title if (1) such services were emergency services and (2) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder. Such payments shall be made only in the amounts provided under section 1812 (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866 (a) .

USE OF CARRIERS OR ORGANIZATIONS TO FACILITATE
PAYMENTS UNDER THIS PART

Sec. 130(a)

SEC. 1855. The Secretary is authorized to enter into such modifications of the agreements entered into pursuant to section 1816 and of the contracts entered into pursuant to section 1842 as he finds necessary in order to facilitate the administration of this part; and for such purposes such sections are applicable to the provisions of this part. To the extent feasible, the Secretary shall utilize the agreements entered into under section 1816 where payment is to be made on a reasonable cost basis and contracts entered into under section 1842 where payment is to be made on a reasonable charge basis. Where the services are furnished by a physician under an arrangement whereby the patient receiving such services discharges his financial liability only by payment to the physician either directly or through his agent, the methods of payment for charges provided under section 1842 shall apply. Payment for the services of a physician shall be made to him (or to the hospital if the physician has assigned his rights to the hospital) by the method provided in section 1842; except that if the physician so elects, payment may, in accordance with regulations, be made to the hospital to reimburse it for compensation paid by it to the physician.

PAYMENT OF BENEFITS

SEC. 1856. Payment for services described in section 1851 (a) shall be made from the Federal Supplementary Medical Insurance Trust Fund. Payment for services described in section 1851 (b) shall be made from the Federal Hospital Insurance Trust Fund.

Part ~~A~~—Miscellaneous Provisions

D

Definitions of Services, Institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) The term “spell of illness” with respect to any individual means a period of consecutive days—

(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of an extended care facility.

Inpatient Hospital Services

(b) The term “inpatient hospital services” means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital—

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

excluding, however—

(4) medical or surgical services provided by a physician, ~~resident,~~
~~or intern;~~ and

(5) the services of a private-duty nurse or other private-duty attendant.

Sec.161(b)(1)

Sec.130(a)

Sec.130(a)

provided in
the hospital (A)

Sec.161(b)(2)

Paragraph (4) shall not apply to services ~~provided in the hospital~~ by an intern or a resident-in-training under a teaching program approved by the Council on Medical Education of the American Medical Association or, in the case of an osteopathic hospital, approved by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, or, in the case of services in a hospital or osteopathic hospital by an intern or resident-in-training in the field of dentistry, approved by the Council on Dental Education of the American Dental Association.

Sec.161(b)(3)

(or (B) by a hospital employee who is authorized by the State in which such hospital is located to practice as a physician only in a hospital .

Inpatient Psychiatric Hospital Services

(c) The term "inpatient psychiatric hospital services" means inpatient hospital services furnished to an inpatient of a psychiatric hospital.

Inpatient Tuberculosis Hospital Services

(d) The term "inpatient tuberculosis hospital services" means inpatient hospital services furnished to an inpatient of a tuberculosis hospital.

Hospital

Sec. 126(a)

(e) The term "hospital" (except for purposes of section ~~1814(d)~~, subsection (a) (2) of this section, paragraph (7) of this subsection, and subsections (i) and (n) of this section) means an institution which—

1814(c)
and section
1854 (b)

Sec.130(c)(11)

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) maintains clinical records on all patients;

(3) has bylaws in effect with respect to its staff of physicians;

(4) has a requirement that every patient must be under the care of a physician;

(5) provides 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times;

(6) has in effect a hospital utilization review plan which meets the requirements of subsection (k) ;

(7) in the case of an institution in any State in which State or applicable local law provides for the licensing of hospitals, (A) is licensed pursuant to such law or (B) is approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing; and

(8) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution, except that such other requirements may not be higher than the comparable requirements prescribed for the accreditation of hospitals by the Joint Commission on Accreditation of Hospitals (subject to the second sentence of section 1863).

ec. 126(a)
ec. 130(c)(11)

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections ~~1814(d)~~ (including determination of whether an individual received inpatient hospital services for purposes of such section), and subsections (i) and (n) of this section, such term includes any institution which meets the requirements of paragraphs (1), (2), (3), (4), (5), and (7) of this subsection. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases or tuberculosis unless it is a tuberculosis hospital (as defined in subsection (g) or unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865.

1814(c)
and section
1854 (b)

Psychiatric Hospital

(f) The term "psychiatric hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons;

(2) satisfies the requirements of paragraphs (3) through (8) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals entitled to hospital insurance benefits under part A;

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "psychiatric hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

Tuberculosis Hospital

(g) The term "tuberculosis hospital" means an institution which—

(1) is primarily engaged in providing, by or under the supervision of a physician, medical services for the diagnosis and treatment of tuberculosis;

(2) satisfies the requirements of paragraphs (3) through (8) of subsection (e);

(3) maintains clinical records on all patients and maintains such records as the Secretary finds to be necessary to determine the degree and intensity of the treatment provided to individuals covered by the insurance program established by part A;

(4) meets such staffing requirements as the Secretary finds necessary for the institution to carry out an active program of treatment for individuals who are furnished services in the institution; and

(5) is accredited by the Joint Commission on Accreditation of Hospitals.

In the case of an institution which satisfies paragraphs (1) and (2) of the preceding sentence and which contains a distinct part which also satisfies paragraphs (3) and (4) of such sentence, such distinct part shall be considered to be a "tuberculosis hospital" if the institution is accredited by the Joint Commission on Accreditation of Hospitals or if such distinct part meets requirements equivalent to such accreditation requirements as determined by the Secretary.

Extended Care Services

(h) The term "extended care services" means the following items and services furnished to an inpatient of an extended care facility and (except as provided in paragraphs (3) and (6)) by such extended care facility—

(1) nursing care provided by or under the supervision of a registered professional nurse;

(2) bed and board in connection with the furnishing of such nursing care;

(3) physical, occupational, or speech therapy furnished by the extended care facility or by others under arrangements with them made by the facility;

(4) medical social services;

(5) such drugs, biologicals, supplies, appliances, and equipment, furnished for use in the extended care facility, as are ordinarily furnished by such facility for the care and treatment of inpatients;

(6) medical services provided by an intern or resident-in-training of a hospital with which the facility has in effect a transfer agreement (meeting the requirements of subsection (1)), under a teaching program of such hospital approved as provided in the last sentence of subsection (b), and other diagnostic or therapeutic services provided by a hospital with which the facility has such an agreement in effect; and

(7) such other services necessary to the health of the patients as are generally provided by extended care facilities;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Extended Care Services

(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the extended care facility within 14

days after discharge from such hospital; and an individual shall be deemed not to have been discharged from an extended care facility if, within 14 days after discharge therefrom, he is admitted to such facility or any other extended care facility.

Extended Care Facility

(j) The term "extended care facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

(2) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;

(3) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;

(4) (A) has a requirement that the health care of every patient must be under the supervision of a physician, and (B) provides for having a physician available to furnish necessary medical care in case of emergency;

(5) maintains clinical records on all patients;

(6) provides 24-hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed as provided in paragraph (2), and has at least one registered professional nurse employed full time;

(7) provides appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(8) has in effect a utilization review plan which meets the requirements of subsection (k);

(9) in the case of an institution in any State in which State or applicable local law provides for the licensing of institutions of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing institutions of this nature, as meeting the standards established for such licensing; and

(10) meets such other conditions relating to the health and safety of individuals who are furnished services in such institution or relating to the physical facilities thereof as the Secretary may find necessary (subject to the second sentence of section 1863);

except that such term shall not (other than for purposes of subsection (a)(2)) include any institution which is primarily for the care and treatment of mental diseases or tuberculosis. For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. The term 'extended care facility' also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection.

Utilization Review

(k) A utilization review plan of a hospital or extended care facility shall be considered sufficient if it is applicable to services furnished by the institution to individuals entitled to insurance benefits under this title and if it provides—

(1) for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished, (A) with respect to the medical necessity of the services, and (B) for the purpose of promoting the most efficient use of available health facilities and services;

(2) for such review to be made by either (A) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or (B) a group outside the institution which is similarly composed and (i) which is established by the local medical society and some or all of the hospitals and extended care facilities in the locality, or (ii) if (and for as long as) there has not been established such a group which serves such institution, which is established in such other manner as may be approved by the Secretary;

(3) for such review, in each case of inpatient hospital services or extended care services furnished to such an individual during a continuous period of extended duration, as of such days of such period (which may differ for different classes of cases) as may be specified in regulations, with such review to be made as promptly as possible, after each day so specified, and in no event later than one week following such day; and

(4) for prompt notification to the institution, the individual, and his attending physician of any finding (made after opportunity for consultation to such attending physician) by the physician members of such committee or group that any further stay in the institution is not medically necessary.

The review committee must be composed as provided in clause (B) of paragraph (2) rather than as provided in clause (A) of such paragraph in the case of any hospital or extended care facility where, because of the small size of the institution, or (in the case of an extended care facility) because of lack of an organized medical staff, or for such other reason or reasons as may be included in regulations, it is impracticable for the institution to have a properly functioning staff committee for the purposes of this subsection.

Agreements for Transfer Between Extended Care Facilities and Hospitals

(1) A hospital and an extended care facility shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written undertaking by the person or body which controls them, there is reasonable assurance that—

(1) transfer of patients will be effected between the hospital and the extended care facility whenever such transfer is medically appropriate as determined by the attending physician; and

(2) there will be interchange of medical and other information necessary or useful in the care and treatment of individuals transferred between the institutions, or in determining whether such individuals can be adequately cared for otherwise than in either of such institutions.

Any extended care facility which does not have such an agreement in effect, but which is found by a State agency (of the State in which such facility is situated) with which an agreement under section 1864 is in effect (or, in the case of a State in which no such agency has an agreement under section 1864, by the Secretary) to have attempted in good faith to enter into such an agreement with a hospital sufficiently close to the facility to make feasible the transfer between them of patients and the information referred to in paragraph (2), shall be considered to have such an agreement in effect if and for so long as such agency (or the Secretary, as the case may be) finds that to do so is in the public interest and essential to assuring extended care services for persons in the community who are eligible for payments with respect to such services under this title.

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide;

(5) medical supplies (other than drugs and biologicals), and the use of medical appliances, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or extended care facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital.

Post-Hospital Home Health Services

(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent dis-

charge from an extended care facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or extended care facility.

Home Health Agency

(o) The term "home health agency" means a public agency or private organization, or a subdivision of such an agency or organization, which—

(1) is primarily engaged in providing skilled nursing services and other therapeutic services;

(2) has policies, established by a group of professional personnel (associated with the agency or organization), including one or more physicians and one or more registered professional nurses, to govern the services (referred to in paragraph (1)) which it provides, and provides for supervision of such services by a physician or registered professional nurse;

(3) maintains clinical records on all patients;

(4) in the case of an agency or organization in any State in which State or applicable local law provides for the licensing of agencies or organizations of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing; and

(5) meets such other conditions of participation as the Secretary may find necessary in the interest of the health and safety of individuals who are furnished services by such agency or organization;

except that such term shall not include a private organization which is not a nonprofit organization exempt from Federal income taxation under section 501 of the Internal Revenue Code of 1954 (or a subdivision of such organization) unless it is licensed pursuant to State law and it meets such additional standards and requirements as may be prescribed in regulations; and except that for purposes of part A such term shall not include any agency or organization which is primarily for the care and treatment of mental diseases.

~~Outpatient Hospital Diagnostic Services~~

~~(p) The term "outpatient hospital diagnostic services" means diagnostic services—~~

~~(1) which are furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital; and~~

~~(2) which are ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;~~

~~excluding, however—~~

~~(3) any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and~~

~~(4) any services furnished under such arrangements unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff.~~

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Services to Hospital Outpatients

Sec.130(c)(2)

(p) The term "services to hospital outpatients"

means—

(1) diagnostic specialty services furnished to an individual as a hospital outpatient; and

(2) services (A) which are furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) and (B) which are ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients;

excluding, however—

(3) any item or service (except diagnostic specialty services) if it would not be included under subsection (b) if furnished to an inpatient of a hospital; and

(4) any services furnished under arrangements referred to in paragraph (2) unless furnished in the hospital or in other facilities operated by or under the supervision of the hospital or its organized medical staff or furnished by another hospital which is qualified to participate under this title.

Physicians' Services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in the last sentence of subsection (b)).

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), or (2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services (unless they would otherwise constitute inpatient hospital services, extended care services, or home health services,

services to hospital outpatients, diagnostic

specialty services to hospital inpatients):

(1) physicians' services;

(2) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills, ~~and hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;~~

or podiatrists' services

(3) diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;

(4) X-ray, radium, and radioactive isotope therapy, including materials and services of technicians;

(5) surgical dressings, and splints, casts, and other devices used for reduction of fractures and dislocations;

(6) rental of durable medical equipment, including iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home (including an institution used as his home)

and, under such regu-

lations as the Secretary may prescribe, the purchase of such equipment;

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(7) ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ, including replacement of such devices; and

(9) leg, arm, back, and neck braces, and artificial legs, arms, and eyes, including replacements if required because of a change in the patient's physical condition.

No diagnostic tests performed in any laboratory which is independent of a physician's office or a hospital shall be included within paragraph (3) unless such laboratory—

(10) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law, or (B) is approved, by the agency of such State or locality responsible for licensing establishments of this nature, as meeting the standards established for such licensing; and

(11) meets such other conditions relating to the health and safety of individuals with respect to whom such tests are performed as the Secretary may find necessary.

Drugs and Biologicals

(t) The term "drugs" and the term "biologicals", except for purposes of subsection (m) (5) of this section, include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

Provider of Services

(u) The term "provider of services" means a hospital, extended care facility, or home health agency.

Reasonable Cost

(v) (1) The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such

principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (A) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (B) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

(2) (A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed an amount equal to the reasonable cost of such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the equivalent of the reasonable cost of the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the reasonable cost of such bed and board furnished in semi-private accommodations (determined pursuant to paragraph (1)) minus the difference between the charge customarily made by the hospital or extended care facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

(4) For purposes of this subsection, the term "semi-private accommodations" means two-bed, three-bed, or four-bed accommodations.

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(5) (A) Notwithstanding any other provision of this title, the term 'reasonable cost' shall include amounts attributable to depreciation of plant and equipment in the case of any provider of service, but only with respect to periods during which such provider of service furnishes, pursuant to such regulations as the Secretary may prescribe, satisfactory assurance that such provider will—

(i) set aside, and keep separate and apart from any other funds or assets, such amounts attributable to depreciation of plant and equipment (including any interest on such amounts) as he may be paid to such provider under this title;

(ii) furnish to the Secretary, at such time or times as he may request, such timely information and reports, with respect to such amounts, as the Secretary finds necessary in performing his functions under this title;

(iii) not utilize such amounts for improper capital expenditures; and

(iv) not utilize such amounts for noncapital expenditures except under such conditions as may be approved, in accordance with regulations prescribed by the Secretary, by the State agency designated pursuant to section 1864 (c).

(B) A capital expenditure by a provider of service shall be deemed improper if the State agency, designated pursuant to section 1864 (c) determines that such capital expenditure does not conform to the overall plan developed, in accordance with regulations prescribed by the Secretary, by such State agency for adequate health care facilities and such provider of service had notice of such overall plan.

(C) Where a provider of service utilizes funds (whether or not such funds include the amounts referred to in subparagraph (A)), for a capital expenditure which, under the provisions of subparagraph (B), are determined to be improper, or such provider fails substantially to comply with clause (i), (ii), or (iv) of subparagraph (A), the Secretary may—

(i) terminate the agreement with such provider of service entered into pursuant to section 1866, and for such purposes the provisions of subsection (b) of such section shall apply, or

(ii) deduct from future payments under this title to such provider of services, for such periods of time as the Secretary finds necessary to effectuate the purposes of this paragraph, the amounts attributable to depreciation of such improper capital expenditure, and such portion (or any part thereof) of other cost of services

to individuals covered by the insurance programs established by this title as the Secretary finds attributable to such improper capital expenditures.

(D) For purposes of this paragraph, a "capital expenditure" means (except to the extent that the meaning of such term shall be modified pursuant to regulations of the Secretary) an expenditure which, under accepted accounting procedures, is not properly chargeable as an expense of operation or maintenance.

Arrangements for Certain Services

(w) The term "arrangements" is limited to arrangements under which receipt of payment by the hospital, extended care facility, or home health agency (whether in its own right or as agent), with respect to services for which an individual is entitled to have payment made under this title, discharges the liability of such individual or any other person to pay for the services.

State and United States

(x) The terms "State" and "United States" have the meaning given to them by subsections (h) and (i), respectively, of section 210.

Post-Hospital Extended Care in Christian Science Extended Care Facilities

(y) (1) The term "extended care facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only (except for purposes of subsection (a) (2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in an extended care facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

(A) furnished an individual during such spell of illness in an extended care facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such spell, or

(ii) such services have been furnished to him during such spell in an extended care facility to which such paragraph does not apply; or

(B) furnished an individual during such spell of illness in an extended care facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in an extended care facility to which such paragraph applies.

(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in an extended care facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(4)).

(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.

Podiatrists' Services

(z) The term "podiatrists' services" means services performed by a doctor of podiatry or surgical chiropody, but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them.

Diagnostic Specialty Services

(z) The term "diagnostic specialty services" means diagnostic X-Ray services and diagnostic laboratory services furnished by a physician to an individual either as an inpatient or an outpatient of a hospital and other services (to the extent defined in regulations of the Secretary) related thereto.

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Exclusions From Coverage

Sec. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1) which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member;

(2) for which the individual furnished such items or services has no legal obligation to pay, and which no other person (by reason of such individual's membership in a prepayment plan or otherwise) has a legal obligation to provide or pay for;

(3) which are paid for directly or indirectly by a governmental entity (other than under this Act and other than under a health benefits or insurance plan established for employees of such an entity), except in such cases as the Secretary may specify;

(4) which are not provided within the United States (except for emergency inpatient hospital services furnished outside the United States under the conditions described in section 1814(f)) ; (e)

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(5) which are required as a result of war, or of an act of war, occurring after the effective date of such individual's current coverage under such part;

(6) which constitute personal comfort items;

(7) where such expenses are for routine physical checkups, eyeglasses or eye examinations for the purpose of prescribing, fitting, or changing eyeglasses, hearing aids or examinations therefor, or immunizations;

(8) where such expenses are for orthopedic shoes or other supportive devices for the feet;

(9) where such expenses are for custodial care;

(10) where such expenses are for cosmetic surgery or are incurred in connection therewith, except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member;

(11) where such expenses constitute charges imposed by immediate relatives of such individual or members of his household; or

(12) where such expenses are for services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting teeth ; or

(13) where such expenses are for routine foot care, including the removal of corns or calluses and the trimming of nails.

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(b) Payment under this title may not be made with respect to any item or service to the extent that payment has been made, or can reasonably be

expected to be made (as determined in accordance with regulations), with respect to such item or service, under a workmen's compensation law or plan of the United States or a State. Any payment under this title with respect to any item or service shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for such item or service has been made under such a law or plan.

Consultation With State Agencies and Other Organizations To Develop Conditions of Participation for Providers of Services

Sec. 1863. In carrying out his functions, relating to determination of conditions of participation by providers of services, under subsections (e) (8), (f) (4), (g) (4), (j) (10), and (o) (5) of section 1861, the Secretary shall consult with the Health Insurance Benefits Advisory Council established by section 1867, appropriate State agencies, and recognized national listing or accrediting bodies, and may consult with appropriate local agencies. Such conditions prescribed under any of such subsections may be varied for different areas or different classes of institutions or agencies and may, at the request of a State, provide higher requirements for such State than for other States; except that, in the case of any State or political subdivision of a State which imposes higher requirements on institutions as a condition to the purchase of services (or of certain specified services) in such institutions under a State plan approved under title I, XVI, or XIX, the Secretary shall impose like requirements as a condition to the payment for services (or for the services specified by the State or subdivision) in such institutions in such State or subdivision.

Use of State Agencies To Determine Compliance by Providers of Services With Conditions of Participation

And To Provide
Programs of
Health-Care
Facility
Planning

Sec. 1864. (a) The Secretary shall make an agreement with any State which is able and willing to do so under which the services of the State health agency or other appropriate State agency (or the appropriate local agencies) will be utilized by him for the purpose of determining whether an institution therein is a hospital or extended care facility, or whether an agency therein is a home health agency, or whether a laboratory meets the requirements of paragraphs (10) and (11) of section 1861(s). To the extent that the Secretary finds it appropriate, an institution or agency which such a State (or local) agency certifies is a hospital; extended care facility, or home health agency (as those terms are defined in section 1861) may be treated as such by the Secretary. The Secretary may also, pursuant to agreement, utilize the services of State health agencies and other appropriate State agencies (and the appropriate local agencies) to do any one or more of the following: (1) to provide consultative services to institutions ~~for~~ ~~agencies~~ to assist them (A) to establish and maintain fiscal records necessary for purposes of this title, or otherwise to qualify as hospitals, extended care facilities, or home health agencies, or (B) to provide information

, agencies, or
laboratories

which may be necessary to permit determination under this title as to whether payments are due and the amounts thereof, and (2) to provide consultative services to institutions, agencies, or organizations to assist in the establishment of utilization review procedures meeting the requirements of section 1861(k) and in evaluating their effectiveness.

(b) The Secretary shall pay any such State, in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (a), and for the Federal Hospital Insurance Trust Fund's fair share of the costs attributable to the planning and other efforts directed toward coordination of activities in carrying out its agreement and other activities related to the provision of services similar to those for which payment may be made under part A, or related to the facilities and personnel required for the provision of such services, or related to improving the quality of such services.

(c) (1) For purposes of administering the provision of section 1861(v) (5), the Secretary shall make an agreement with any State which is able and willing to do so under which he will be authorized to utilize the services of a State agency (designated by the State) which (A) provides for health-care facility and equipment planning in all political subdivisions of the State to meet the needs in the most efficient and economical manner possible of residents of the States for adequate health-care, (B) coordinates its activities with other agencies engaged in health service planning and participate in interstate and regional health-care facility program, (C) assists the health-care facilities located within the State with their programs of planning for carrying on

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health, educational and research activities, including related educational and research activities, and (D) if the agency designated by the State is other than an agency established pursuant to section 314 (a) (2) of the Public Health Service Act, coordinates (or provides reasonable assurance that it will coordinate) its activities under section 1861 (v) (5) with, and in these activities is guided by the planning policies and procedures of, the agency established pursuant to such section 314 (a) (2).

(2) The Secretary shall pay from the Federal Hospital Insurance Trust Fund to any State with which he makes an agreement described in paragraph (1), in advance or by way of reimbursement, as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made) for the reasonable cost of performing the services for purposes of carrying out paragraph (5) (B) of section 1861 (v).

Effect of Accreditation

Sec. 1865. Except as provided in the second sentence of section 1863, an institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861 (e) (except paragraph (6) thereof) if such institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals. If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan or imposes another requirement which serves substantially the same purpose, the Secretary is authorized to find that all institutions so accredited by the Commission comply also with section 1861 (e) (6). In addition, if the Secretary finds that accreditation of an institution or agency by the American Osteopathic Association or any other national accreditation body provides reasonable assurance that any or all of the conditions of section 1861 (e), (j), or (o), as the case may be, are met, he may, to the extent he deems it appropriate, treat such institution or agency as meeting the condition or conditions with respect to which he made such finding.

Agreements With Providers of Services

Sec. 1866. (a) (1) Any provider of services shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.

(2) (A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a) (1), ~~(a) (2), or (a) (4)~~, section 1833(b), or section 1861(y) (3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B or, in the case of ~~outpatient hospital diagnostic services, for which payment is made under part A~~. In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section.

(B) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this title, such provider of services may also charge such individual or other person for such more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this title.

(C) A provider of services may also charge any such individual for any whole blood furnished him with respect to which a deductible is imposed under section 1813(a) (3), except that (i) any excess of such charge over the cost to such provider for the blood shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood, and (iii) such charge may not be made to the extent such blood has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf.

(b) An agreement with the Secretary under this section may be terminated—

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this title and regulations thereunder, or (B) that such provider of services no longer substantially

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(d)

or (a)(3)

services to hospital outpatients, as defined in section 1861(p)(2)

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meets the applicable provisions of section 1861, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this title and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be necessary to verify such information.

Any termination shall be applicable—

(3) in the case of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to such services furnished to any individual who is admitted to the hospital or extended care facility furnishing such services on or after the effective date of such termination,

(4) (A) with respect to home health services furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

(5) with respect to any other items and services furnished on or after the effective date of such termination.

(c) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or extended care facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of an extended care facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

Health Insurance Benefits Advisory Council

Sec. 1867. For the purpose of advising the Secretary on matters of general policy in the administration of this title and in the formulation of regulations under this title, there is hereby created a Health Insurance Benefits Advisory Council which shall consist of 16 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, and at least one person who is representative of the general public. Each member shall hold office for a term of 4 years, except that any

member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, four at the end of the first year, four at the end of the second year, four at the end of the third year, and four at the end of the fourth year after the date of appointment. A member shall not be eligible to serve continuously for more than 2 terms. The Secretary may, at the request of the Council or otherwise, appoint such special advisory professional or technical committees as may be useful in carrying out this title. Members of the Advisory Council and members of any such advisory or technical committee, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council or of such committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently. The Advisory Council shall meet as frequently as the Secretary deems necessary. Upon request of 4 or more members, it shall be the duty of the Secretary to call a meeting of the Advisory Council.

National Medical Review Committee

Sec. 1868. (a) There is hereby created a National Medical Review Committee (hereinafter in this section referred to as the "Committee") which shall consist of ~~nine~~ sixteen persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the civil service laws. The Secretary shall from time to time appoint one of the members to serve as chairman. The members shall be selected from among individuals who are representative of organizations and associations of professional personnel in the field of medicine and other individuals who are outstanding in the field of medicine or in related fields; except that at least one member shall be representative of the general public, and at least a majority of the members shall be physicians. Each member shall hold office for a term of ~~three~~ four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term, and except that the terms of office of the members first taking office shall expire, as designated by the Secretary at the time of appointment, ~~three~~ four at the end of the first year, ~~three~~ four at the end of the second year, ~~and three~~ and four at the end of the third year, ~~after~~ and four at the end of the fourth year the date of appointment. A member shall not be eligible to serve continuously for more than two terms.

(b) Members of the Committee, while attending meetings or conferences thereof or otherwise serving on business of the Committee, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, including travel time, and while so serving away from their

sixteen

four

, and four at the end of the fourth year

Sec.128(1)

Sec,128(2)

homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5 of the Administrative Expenses Act of 1946 (5 U.S.C. 73b-2) for persons in the Government service employed intermittently.

(c) It shall be the function of the Committee to study the utilization of hospital and other medical care and services for which payment may be made under this title with a view to recommending any changes which may seem desirable in the way in which such care and services are utilized or in the administration of the programs established by this title, or in the provisions of this title. The Committee shall make an annual report to the Secretary of the results of its study, including any recommendations it may have with respect thereto, and such report shall be transmitted promptly by the Secretary to the Congress.

(d) The Committee is authorized to engage such technical assistance as may be required to carry out its functions, and the Secretary shall, in addition, make available to the Committee such secretarial, clerical, and other assistance and such pertinent data obtained and prepared by the Department of Health, Education, and Welfare as the Committee may require to carry out its functions.

Determinations; Appeals

Sec. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b) Any individual dissatisfied with any determination under subsection (a) as to entitlement under part A or part B, or as to amount of benefits under part A where the matter in controversy is \$100 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b), and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is \$1,000 or more, to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b) (2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

Overpayments on Behalf of Individuals

Sec. 1870. (a) Any payment under this title to any provider of services or other person with respect to any items or services furnished any individual shall be regarded as a payment to such individual.

And Settlement
Of Claims For
Benefits on
Behalf Of
Deceased
Individuals

Sec. 153(b)

(b) Where—

(1) more than the correct amount is paid under this title to a provider of services or other person for items or services furnished an individual and the Secretary determines that, within such period as he may specify, the excess over the correct amount cannot be recouped from such provider of services or other person, or

Sec. 126(a)

(2) any payment has been made under section 1814~~(e)~~ to a provider of services or other person for items or services furnished an individual,

(d)

proper adjustments shall be made, under regulations prescribed (after consultation with the Railroad Retirement Board) by the Secretary, by decreasing subsequent payments—

(3) to which such individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, or

(4) if such individual dies before such adjustment has been completed, to which any other individual is entitled under title II of this Act or under the Railroad Retirement Act of 1937, as the case may be, with respect to the wages and self-employment income or the compensation constituting the basis of the benefits of such deceased individual under title II of such Act.

As soon as practicable after any adjustment under paragraph (3) or (4) is determined to be necessary, the Secretary, for purposes of this section, section 1817(g), and section 1841(f), shall certify (to the Railroad Retirement Board if the adjustment is to be made by decreasing subsequent payments under the Railroad Retirement Act of 1937) the amount of the overpayment as to which the adjustment is to be made.

(c) There shall be no adjustment as provided in subsection (b) (nor shall there be recovery) in any case where the incorrect payment has been made (including payments under section 1814~~(e)~~) with respect to an individual who is without fault and where such adjustment (or recovery) would defeat the purposes of title II or would be against equity and good conscience.

Sec. 126(a)

(d)

(d) No certifying or disbursing officer shall be held liable for any amount certified or paid by him to any provider of services or other person where the adjustment or recovery of such amount is waived under subsection (c) or where adjustment under subsection (b) is not completed prior to the death of all persons against whose benefits such adjustment is authorized.

Sec. 153(c)

(e) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and payment for such services was made (other than under this title) and the individual died before any payment due with respect to such services was completed, payment of the amount due (including the amount of any unnegotiated checks) shall be made—

(1) if such payment for such services was made by a person other than the deceased individual, to the person or persons determined by the Secretary under regulations prescribed by him to have paid for such services;

(2) if such payment for such services was made by the deceased individual before his death, or if there is no person to whom payment can be made under paragraph (1) (or if each such person dies before such payment is completed), (A) to the legal representative of the estate of such deceased individual, if any; (B) if there is no legal representative, to the person, if any, determined by the Secretary to be the surviving spouse of the deceased individual and to have been living in the same household with the deceased at the time of his death; (C) if there is no person who meets the requirements of clause (A) or (B), or if each such person dies before payment due him under this title is completed, to the person, if any, determined by the Secretary to be a spouse of the deceased individual who was, for the month

in which the deceased individual died, entitled to a monthly benefit under title II on the basis of the same wages and self-employment income as was the deceased individual; or (D) if there is no person who meets the requirements of clause (A), (B) or (C), or if each such person dies before payment due him under this title is completed, to the person or persons, if any, determined by the Secretary to be the child or children of such deceased individual (and in case there is more than one such child, in equal parts to each such child) ; or (E) if there is no person who meets the requirements of clause (A), (B), (C) or (D), or if each such person dies before payment due him under this title is completed, to such person or persons, related to such deceased individual by blood, marriage, or adoption, as the Secretary determines (under such regulations as he may prescribe) to be the proper person or persons to receive such payment on behalf of the estate of such deceased individual.

(f) If an individual who received medical and other health services for which payment may be made under section 1832 (a) (1) dies, and (1) no assignment of the right to payments was made by such individual before his death, and (2) payment for such services has not been made, payment for such services shall be made to the physician or

other persons who provided such services. Payment shall be made under this subsection only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.

Regulations

Sec. 1871. The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this title. When used in this title, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

Application of Certain Provisions of Title II

Sec. 1872. The provisions of sections 206, 208, and 216(j), and of subsections (a), (d), (e), (f), (h), (i), (j), (k), and (l) of section 205, shall also apply with respect to this title to the same extent as they are applicable with respect to title II.

Designation of Organization or Publication by Name

Sec. 1873. Designation in this title, by name, of any nongovernmental organization or publication shall not be affected by change of name of such organization or publication, and shall apply to any successor organization or publication which the Secretary finds serves the purpose for which such designation is made.

Administration

Sec. 1874. (a) Except as otherwise provided in this title and in the Railroad Retirement Act of 1937, the insurance programs established by this title shall be administered by the Secretary. The Secretary may perform any of his functions under this title directly, or by contract providing for payment in advance or by way of reimbursement, and in such installments, as the Secretary may deem necessary.⁵

(b) The Secretary may contract with any person, agency, or institution to secure on a reimbursable basis such special data, actuarial information, and other information as may be necessary in the carrying out of his functions under this title.

Studies and Recommendations

Sec. 1875. (a) The Secretary shall carry on studies and develop recommendations to be submitted from time to time to the Congress relating to health care of the aged, including studies and recommendations concerning (1) the adequacy of existing personnel and facilities for health care for purposes of the programs under parts A and B; (2) methods for encouraging the further development of efficient and economical forms of health care which are a constructive alternative to inpatient hospital care; and (3) the effects of the deductibles and coinsurance provisions upon beneficiaries, persons who provide health services, and the financing of the program.

(b) The Secretary shall make a continuing study of the operation and administration of the insurance programs under parts A and B, and shall transmit to the Congress annually a report concerning the operation of such programs.

SOCIAL SECURITY AMENDMENTS OF 1965**Transitional Provision on Eligibility of Presently Uninsured
Individuals for Hospital Insurance Benefits**

Sec. 103. (a) Anyone who—

(1) has attained the age of 65,

(2) (A) attained such age before 1968, or (B) has not less than 3 quarters of coverage (as defined in title II of the Social Security Act or section 5(1) of the Railroad Retirement Act of 1937), whenever acquired, for each calendar year elapsing after 1965 and before the year in which he attained such age,

(3) is not, and upon filing application for monthly insurance benefits under section 202 of the Social Security Act would not be, entitled to hospital insurance benefits under section 226 of such Act, and is not certifiable as a qualified railroad retirement beneficiary under section 21 of the Railroad Retirement Act of 1937 (as added by section 105(a) of this Act),

(4) is a resident of the United States (as defined in section 210(i) of the Social Security Act), and is (A) a citizen of the United States or (B) an alien lawfully admitted for permanent residence who has resided in the United States (as so defined) continuously during the 5 years immediately preceding the month in which he files application under this section, and

(5) has filed an application under this section in such manner and in accordance with such other requirements as may be prescribed in regulations of the Secretary,

shall (subject to the limitations in this section) be deemed, solely for purposes of section 226 of the Social Security Act, to be entitled to monthly insurance benefits under such section 202 for each month, beginning with the first month in which he meets the requirements of this subsection and ending with the month in which he dies, or, if earlier, the month before the month in which he becomes (or upon filing application for monthly insurance benefits under section 202 of such Act would become) entitled to hospital insurance benefits under section 226 or become certifiable as a qualified railroad retirement beneficiary. An individual who would have met the preceding requirements of this subsection in any month had he filed application under paragraph (5) hereof before the end of such month shall be deemed to have met such requirements in such month if he files such application before the end of the twelfth month following such month. No application under this section which is filed by an individual more than 3 months before the first month in which he meets the requirements of paragraphs (1), (2), (3), and (4) shall be accepted as an application for purposes of this section.

(b) The provisions of subsection (a) shall not apply to any individual who—

~~(1) is, at the beginning of the first month in which he meets the requirements of subsection (a), a member of any organization referred to in section 210(a) (17) of the Social Security Act,~~

~~(2) has, prior to the beginning of such first month, been convicted of any offense listed in section 202(u) of the Social Security Act, or~~

~~(3) (A) at the beginning of such first month is covered by an enrollment in a health benefits plan under the Federal Employees Health Benefits Act of 1959,~~

~~(B) was so covered on February 16, 1965, or~~

~~(C) could have been so covered for such first month if he or some other person had availed himself of opportunities to enroll in a health benefits plan under such Act and to continue such enrollment (but this subparagraph shall not apply unless he or such other person was a Federal employee at any time after February 15, 1965).~~

~~Paragraph (3) shall not apply in the case of any individual for the month (or any month thereafter) in which coverage under such a health benefits plan ceases (or would have ceased if he had had such coverage) by reason of his or some other person's separation from Federal service, if he or such other person was not (or would not have been) eligible to continue such coverage after such separation.~~

(c) There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund (established by section 1817 of the Social Security Act) from time to time such sums as the Secretary deems necessary for any fiscal year, on account of—

(1) payments made or to be made during such fiscal year from such Trust Fund under part A of title XVIII of such Act with respect to individuals who are entitled to hospital insurance benefits under section 226 of such Act solely by reason of this section,

(2) the additional administrative expenses resulting or expected to result therefrom, and

(3) any loss in interest to such Trust Fund resulting from the payment of such amounts,

in order to place such Trust Fund in the same position at the end of such fiscal year in which it would have been if the preceding subsections of this section had not been enacted.

Sec. 110(a)

SUSPENSION IN CASE OF ALIENS; PERSONS CONVICTED OF SUBVERSIVE
ACTIVITIES

SEC. 104. (a)(1) Section 202(t) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"(9) No payments shall be made under part A of title XVIII with respect to items or services furnished to an individual in any month for which the prohibition in paragraph (1) against payment of benefits to him is applicable (or would be if he were entitled to any such benefits)."

(2) Section 202(u) of such Act is amended by striking out "and" before the phrase "in determining the amount of any such benefit payable to such individual for any such month," and inserting after such phrase "and in determining whether such individual is entitled to insurance benefits under part A of title XVIII for any such month,".

(b)~~(1)~~ No payments shall be made under part B of title XVIII of the Social Security Act with respect to expenses incurred by an individual during any month for which such individual may not be paid monthly benefits under title II of such Act (or for which such monthly benefits would be suspended if he were otherwise entitled thereto) by reason of section 202(t) of such Act (relating to suspension of benefits of aliens who are outside the United States).

~~(2) An individual who has been convicted of any offense under (A) chapter 37 (relating to espionage and censorship), chapter 105 (relating to sabotage), or chapter 115 (relating to treason, sedition, and subversive activities) of title 18 of the United States Code, or (B) section 4, 112, or 113 of the Internal Security Act of 1950, as amended, may not enroll under part B of title XVIII of the Social Security Act.~~

Sec. 110(b)

The Railroad Retirement Act of 1937

HOSPITAL INSURANCE BENEFITS FOR THE DISABLED

Sec. 125(b)

'SEC. 22. Individuals under age sixty-five who are entitled to annuities under paragraph 4 or 5 of section 2 (a) or are entitled to annuities under section 5 (c) (or who have been or would be considered in applying the provisions of section 3 (e) (3)) and have attained the age of eighteen and have a disability (within the meaning of section 5 (1) (1) (ii)) and who are in a 'period of disability' (as this term is described in section 3 (e)) and, with respect to individuals entitled to annuities under paragraph 4 or 5 of section 2 (a) , are not in a 'waiting period' (as defined in section 223 (c) (3) of the Social Security Act) shall be certified by the Board under section 21 in the same manner, for the same purposes, and subject to the same conditions, restrictions, and other provisions as individuals specifically described in such section 21, and also subject to the same conditions, restrictions, and other provisions as are disability beneficiaries under title II of the Social Security Act in connection with their eligibility for hospital insurance benefits under part A of title XVIII of such Act and their eligibility to enroll under part B of such title XVIII; and for the purposes of this Act and title XVIII of the Social Security Act, individuals certified as provided in this section shall be considered individuals described in and certified under such section 21.

EFFECTIVE DATES

With the exception of the amendments listed below and those amendments in which the effective date is shown in the text, the amendments to be made by H.R. 5710 will generally be effective on the day of enactment.

<u>Amending Section</u>	<u>Effective</u>
110(a)	July 30, 1965 (Sec. 110(e)(1))
110(b)	July 30, 1965 (Sec. 110(e)(1))
126(a)	Effective with respect to services furnished after December 31, 1967. (Sec. 126(c))
126(b)	Effective with respect to services furnished after December 31, 1967. (Sec. 126(c))
127(a)	Effective with respect to services furnished after June 30, 1967. (Sec. 127(c))
127(b)	Effective with respect to services furnished after June 30, 1967. (Sec. 127(c))
129(a)(1)	Effective with respect to payments under title XVIII to providers of services for services provided after June 30, 1968. (Sec. 129(a)(2))
131(a)(1)	Effective with respect to payments under title XVIII for services provided after June 30, 1967. (Sec. 131(b))
131(a)(2)	Effective with respect to payments under title XVIII for services provided after June 30, 1967. (Sec. 131(b))
131(a)(3)	Effective with respect to payments under title XVIII for services provided after June 30, 1967. (Sec. 131(b))

Amending Section

Effective

131(a)(4)

Effective with respect to payments under title XVIII for services provided after June 30, 1967. (Sec. 131(b))

131(a)(5)

Effective with respect to payments under title XVIII for services provided after June 30, 1967. (Sec. 131(b))

161(a)

Effective with respect to services furnished under title XVIII after June 30, 1967. (Sec. 161(c))

161(b)(1)

Effective with respect to services furnished under title XVIII after June 30, 1967. (Sec. 161(c))

161(b)(2)

Effective with respect to services furnished under title XVIII after June 30, 1967. (Sec. 161(c))

161(b)(3)

Effective with respect to services furnished under title XVIII after June 30, 1967. (Sec. 161(c))

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